LAKESHORE
SPEECH THERAPY, LLC.

LAKESHORE SPEECH THERAPY
CREDIT CARD AUTHORIZATION

PATIENT INFORMATION	
Patient Name	
Zip Code	
***Retain on file:**	Yes No

CREDIT CARD INFORMATION	
Card Holder's Full Name	
Credit Card Number	
Expiration Date	
CVC Number (3 digit on back/4 digit on front)	

FINANCIAL AUTHORIZATION

I, _____, as parent/guardian/cardholder, authorize the above credit card information may be used as either a one time use or to be retained on file for current and future uses (box above had been check yes or no.) This information will remain confidential and will be shred upon client discharge or card holder's request.

Signature	Date